Meeting Minutes
Health Information Technology Council Meeting

December 9, 2013
3:30 – 5:00 P.M.

One Ashburton Place, 21th floor Matta Conference Room
Boston, MA

Meeting Attendees

Name	Organization	Attended
John Polanowicz	*(Chair) Secretary of the Executive Office of Health and Human Services*	Yes
Manu Tandon	*(Chair) Secretariat Chief Information Officer of the Executive Office of Health and Human Services, Mass HIT Coordinator*	Yes
Darrel Harmer	*Acting Chief Information Officer, Commonwealth of Massachusetts*	Yes
David Seltz	*Executive Director of Health Policy Commission*	yes
Aron Boros	*Executive Director of Massachusetts Center for Health Information and Analysis*	Yes
Laurance Stuntz	*Director, Massachusetts eHealth Institute*	Yes
Eric Nakajima	*Assistant Secretary for Innovation Policy in Housing and Economic Development*	Yes
Patricia Hopkins MD	*Representative from a small Physician group Practice Rheumatology & Internal Medicine Doctor (Private Practice)*	Yes
Meg Aranow	*Senior Research Director, The Advisory Board Company*	Yes
Deborah Adair	*Director of Health Information Services/Privacy Officer, Massachusetts General Hospital*	Yes
John Halamka, MD	*Chief Information officer, Beth Israel Deaconess Medical Center*	Yes
Normand Deschene	*President and Chief Executive Officer , Lowell General Hospital*	No
Jay Breines	*Executive Director, Holyoke Health Center*	No
Robert Driscoll	*Chief Operations Officer, Salter Healthcare*	Yes
Michael Lee, MD	*Director of clinical Informatics, Atrius Health*	Yes
Margie Sipe, RN	*Nursing Performance Improvement Innovator, Lahey Clinic*	Yes
Steven Fox	*Vice President, Network Management and Communications, Blue Cross Blue Shield MA*	Yes
Larry Garber, MD	*Medical Director of Informatics, Reliant Medical Group*	Yes
Karen Bell, MD	*Chair of the Certification Commission for Health Information Technology (CCHIT) EOHED*	Yes
Kristin Madison	*Professor of Law and Health Sciences, Northeastern School of Law, Bouve college of Health Sciences*	Yes
Daniel Mumbauer	*President & CEO, Southeast Regional Network, High Point Treatment Center, SEMCOA*	Yes
Kristin Thorn	*Acting Director of Medicaid*	Yes

Guest

Name	Organization
Robert McDevitt	EOHHS
Nick Welch	EOHHS
Kathleen Snyder	EOHHS
Claudia Boldman	ITD
Sean Kennedy	MeHI

Jennifer Monahan	MAeHC
Micky Tripathi	MAeHC
Mark Belanger	MAeHC
Carol Jeffery	MAeHC
David Smith	MA Hospitals
Lisa Fenichel	Consultant
Sarah Moore	Tufts Medical Center
Dave Bachard	NEQCA
Nicole Heim	Milford Regional Medical Center

Meeting called to order – minutes approved

The meeting was called to order by Secretary John Polanowicz at 3:33 P.M.

The Council reviewed minutes of the October, 2013 HIT Council meeting. The minutes were approved as written.

Discussion Item 1: Mass HIway Year in Review (Slides 3-13)

See slides 3-13 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

The Mass HIway year in review was presented by Manu Tandon, Executive Office of Health and Human Services (EOHHS) Secretariat Chief Information Officer and Massachusetts Health IT Coordinator.

Manu Tandon provided the group with an overview of the current state of the HIway and the road ahead. It is clear that there is intent to use the HIway; there is a market and a need for it when looking at who has joined and who is in the pipeline. There is also a good diversity of providers on the HIway as well as broad geographical reach – this is not just a Boston HIE. There is a need to do more to help people not only connect to the HIE, but to identify optimal use. In some ways this is a call for action to the HIT Council to promote the HIE in their respective organizations.

The Council was informed that Darrel Harmer was hired as the Assistant CIO for the HIway at EOHHS. However, due to John Letchford resignation as CIO for the Commonwealth, Darrel is serving as acting CIO until his replacement start in January. In early January he will begin his duties as ACIO for the HIway and will be a regular feature at the Council meetings in the near future.

(Slide 4) Original Goals- The Council revisited the Strategic Goals set out a year ago in the 2012 Health IT Strategic Plan. See slide for goals.

(Slide 5) Growing Use and Impact- The primary use of the HIway has supported these Strategic Goals through four main use cases: case management, public health reporting, care coordination, and quality improvement.

(Slide 6-) Support Case Management- Organization types using the HIway for case management include hospitals/health systems and payers. Over 21,236 case management transactions have been exchanged using the HIway. Improved case management is expected to have a positive impact on quality, cost reduction, and patient satisfaction.

(Slide 7) Support Public Health- There are a number of different types of organizations using the HIway for Public Health Reporting. To date there have been 52,261 public health transactions conducted over the Mass HIway.

(Slide 8) Support Quality Improvement- Beth Israel Deaconess Medical Center (BIDMC) and The Massachusetts eHealth Collaborative (MAeHC) are actively using the HIway to exchange data live in production.

(Slide 9) Support Care Coordination- This is where you start appreciating the diversity of organizations that have joined the HIway. You can see that it is not just hospitals joining. The number of transactions is low right now; it would be a good benchmark to look at this in December of next year. There is no doubt of intent or diversity, but we are not quite there in terms of volume; the bottom line is that there is still more work to be done.

(Slide 10) Connecting Participants- A map of participants by go-live status was provided. A majority of the action is happening in the Worchester, Springfield and Boston areas.

(Slide 11) Early Movers- Clearly BIDMC and Tufts are ahead; BIDMC is pursuing all four of the use cases, Tufts is pursuing three, both with a healthy group of trading partners.

(Slide 12) HIway 2013 Milestones- Centers for Medicare and Medicaid Services (CMS) support and funding has been a constant on this project; back in April the funding was approved. There were a series of nodes on the Public Health side that went live. The design of the Health Information Services Provider (HISP) to HISP Solution is almost complete. We knew the HISP to HISP solution had to be dealt with, but we did not forecast how quickly we would need it and how complex the solution would be.

In November the coding and testing for Phase 2 was started, the work is going well, looking to launch this in January. Recently we submitted the Implementation Advance Planning Document (IAPD) for continued Federal support over the next two fiscal years.

Slide 13 was presented by John Halamka, MD, CIO, Beth Israel Deaconess Medical Center (BIDMC)

(Slide 13) Mass HIway- The Road Ahead- First it is important to look at the national, regional and local changes that have happened over the past two years. Last Friday night (December 6th) there was a misleading announcement from CMS around extending the Meaningful Use (MU) timeline; it is not a delay in the Stage 2 MU timeline, it's a delay in the Stage 3 timeline for providers who have been

meeting all of the Stage 1 and Stage 2 requirements. For MU Stage 2, there is already a lot of anxiety about reaching interoperability needs, but the Department of Health and Human Services (HHS) has not telegraphed any delay for Stage 2. The Stage 3 timeline was going to begin in 2016, it will now start in 2017. That means that in 2014 the transition of care requirements are enforced, creating motivation to join the HIE. EHR vendors that have been certified for the 2014 standards have the capability to connect to the state HIE in some capacity.

There are certain vendors that feel they are not only an EHR vendor but also a HISP vendor, transporting data for a fee. The HIway needs to be the HISP "that serves everyone" and connects to everyone; eClinicalWorks (eCW), Surescripts and Athenahealth for example.

Interestingly enough, the Affordable Care Act (ACA) is providing another strong motivator. There are a number of private payer contracts that will charge for repeat testing and readmissions so there is an unbelievable need to have transition of care data. Unless all facilities and patients are connected, providers will not survive financially. This will accelerate use and should remove redundancy and reduce cost.

The Health Insurance Portability and Accountability Act (HIPAA) Omnibus and anticipated Accounting for Disclosures rules require more focus on care communities. Wouldn't it be nice to have a single point of disclosure? The HIway can be the audit trail for patients and government regulators. There is a means of saying, "what was requested and what was sent?"

Between Meaningful Use, ACA, Health Insurance Portability and Accountability Act Omnibus, and International Classification of Disease (ICD) 10, all benefit from the MA HIway, the incentives are increasingly in line with the federal requirements.

- Question (Deborah Adair): Do we have metrics in terms of on-boarding in other states?
    - Answer (Micky Tripathi): There are HIE activities that have been going on for a fair amount of time; Rochester, Albany, Cincinnati are all older style HIEs with repositories, this predates the HITECH stuff. If you think about where we are with the Direct based models being looked at today some offer Direct for free and have thousands of providers "signed up" but not using the HIE; NY, Florida and Rhode Island for example. The MA model is running ahead of where most places are.
- Question (Manu Tandon): A number of us have experience with The New England Healthcare Exchange Network (NEHEN) in the early days, how does the on-boarding timeline compare to the HIway?
    - Answer (John Halamka)-(Posed question to Laurance Stuntz who was directly involved with NEHEN when it started): How long did it take you to build NEHEN?
    - Answer (Laurance Stuntz): I started working on NEHEN in 1999 with Boston Medical and UMass Memorial; We started in January of that year and finished in September so it took around 9 months. For the first adopters it did take a long time. Today (referring now to Mass HIway last mile program) we are doing 32 projects simultaneously with the implementation grants. There is still a 6 months or so integration timeline, but now with

80 plus organizations. Harvesting those use cases will be hugely beneficial to pave the way moving forward next year.

- Question (Manu Tandon): In terms of pace, how many years did you get 65 hospitals going?
    - Answer (Laurance Stuntz): Six years to get critical mass – [NEHEN is] doing roughly 100 million transactions a year today.
- Comment (Deborah Adair): The use of Continuity of Care Documents (CCDs) will start the value of it; as we expand and people connect, people will get used to that CCD exchange, especially patients. We can then ramp up to send more than CCD's.

The other motivator that has a high utility will be the provider directly. The HIway has created a way to tell the sending provider where the intended receiving provider is at the organizational level. Information is being sent organization to organization, hospital to hospital. The certificates are not by the individual, instead data is sent to the "front door" of the organization. It could be fax, through the EHR, secure email, or whatever means the provider would like. There are a variety of ways to manage and populate the directory because the standards were not defined at the level of granularity needed. The Federal Standards Committee has been charged with sorting this out in 2014.

With every passing month there are more and more transactions and use cases, more EHRs connected. A number of providers are ready to connect, but vendors, like NextGen are not quite ready to connect to anyone. Massachusetts and the HIway will be the first connection to the eCW as a vendor.

- Question (Patricia Hopkins): When you get information from NextGen and you have eCW what do you do?
    - Answer (John Halamka): eCW has its own cloud and can see and connect to any eCW user. Athena also has its own cloud so when it wants to send information to eCW the HIway is not involved. It would be great if there was some way to convene some of these vendors to come with a common trust bundle.
- Question (Patricia Hopkins): How will you manage the data coming in? If I am requesting the CCD or Continuity of Care Record (CCR) in that case, is this like a faxed item I am scanning into my EHR?
    - Answer (John Halamka): MU Stage 2 certified technology must ingest a CCD (no faxing, cut and paste or scanning). It must be structured data in the EHR where in Stage 1 it could be just a document attachment.
- Question (Patricia Hopkins): We do this with claims data updates through the pharmacy. If I want to send lab results from Epic to eCW will data beyond the Consolidated Clinical Document Architecture (CCDA) be sent, like point of service information?
    - Answer (John Halamka): The HIway is content agnostic; it is an issue of what the sending and receiving vendors can do. At the moment we are limited by EHR functionality.
- Comment (Manu Tandon): In 2014 there will be a lot of pressure on vendors. I believe our goals in 2014 should be to not only help people on board but also get the optimal use out of the HIE.
- Comment (John Halamka): The market will continue to evolve, some things were envisioned, while other things are happening that were not envisioned

- Question (Patricia Hopkins): It seems to me that after the CCDA exchange comes in, the next step would need to be laboratory and it seems that there are not a lot of vendors that can do this.
    - Answer (John Halamka): Today most labs are exchanged through point-to-point connections, similar to a string and two paper cups. This would be cheaper for them, but it is more of a question of wanting them to change, they are pretty hard wired.
- Comment (Michael Lee): 80% of labs are done at hospital labs right now, you may want Quest to join, but they only do a small amount of the labs.
- Comment (Laurance Stuntz): When you look at opportunities for the HIway, many organizations are building one-off interfaces, which is expensive. The issue is that most of the EHR Direct products expect you to send a CCD. They have not opened up those products yet to accept Direct transport. When you send them a Health Level 7 (HL7) lab, it would make things much moer agile. There are also a number of one-off propriety agreements.
- Comment (Patricia Hopkins): Beyond what we are talking about, on the pharmacy side of it. Life insurance and risk companies are on the Pharmacy Benefit Manager (PBM) servers. Patients cannot remember the drug they took two months ago, let alone 5 years ago. Is there a way for the HIway to have an add-on system of PBMs that have a historical data for query? The average patient on Medicare has 9 physicians; updated information is important to look at.
- Comment (Deborah Adair): I would like to hear more about the vendor integration and the strategy there, in terms of consent, consent for the HIway, all sorts of things, getting really challenging.
    - Response (Manu Tandon): We will bring that information to the next meeting.

Discussion Item 1: Mass HIway Year in Review (Slides 14-17)

See slides 14-17 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Advisory group updates were presented by Micky Tripathi, CEO of the Massachusetts eHealth Collaborative (MAeHC).

The Technology Advisory Group did not meet this month. The Consumer, Provider, and Legal & Policy Advisory Groups have all met since our last HIT Council meeting.

(Slide 15) Consumer Advisory Group Update- The Consumer Advisory Group reviewed the patient facing collateral that providers can use directly or use to create their own collateral. The group met with Amy Caron, the new communications manager for EOHHS. The overarching concern raised was around informing and educating patients that there are both risks and benefits. There was also discussion around explaining how data is shared today.

(Slide 16) Provider Advisory Group Update- The Provider Advisory Group also looked over the collateral, discussed the vendor issues, as well as the Chapter 224 requirements .The HIway cannot dictate to the vendors what they will charge in terms of committing to the HIway. With the “Meditech model” they do not charge for connection, they may charge for the upgrade to the Meaningful Use Stage 2 version. For

general access to other HISPs, some may charge a flat fee per provider per month, on the other end some will charge by transaction. Epic is charging by the transaction, both incoming and outbound.

The Provider Advisory Group also discussed the Chapter 224 requirement for Providers to connect to the statewide HIE. There were concerns about the overall process and ongoing issues. Other issues to flag: How do you define "provider?" How do you define "connect?" If I am connected to PVIX, does that count? What are the penalties if I do not connect? They also had suggestions on the communication language.

- Comment (Michael Lee): Particularly with small providers there is a fear that they will be left out. The anchor tenants are very important, but there are number of technical hurdles for small providers.
- Question (Steven Fox): I thought there was discussion around convening the vendors and have a conversation with everyone in the same room around the use of the HIway. We cannot get in the way of commerce, but if it becomes a barrier to entry, it seems that there should be Q&A about how to combat this.
    - Answer (John Halamka): In the beginning we tried to offer vendor grants, they declined because they did not want to be responsible for the grant money.
- Comment (John Polanowicz): It would be helpful to have a group discussion if vendors are sitting there building their own toys and have no idea what we are trying to achieve.
- Comment (Steven Fox): If no other market is doing this the way we are doing this and if we do not stand in front of it, we need to have some way to get them to understand where we are going. Seems like right now there is a not a lot of transparency.

(Slide 17) Legal and Policy Advisory Group Update- The Group dug into the provider directory, such as looking at the information that is stored in in the Provider Directory. There are different degrees of concern about what information will be exposed in the directory; things like including providers DEA #'s, what insurance they take. The recommendation was to have the least amount of information possible. The group started to walk through questions of permitted users and permitted user access, whether or not someone can sell the information for marketing purposes. In some HISP models we are allowing eCW access to the provider directory. Not surprisingly, they came to the conclusion that those HISP contracts need to mirror the HIway policies.

- Comment (John Polanowicz): In terms of being transparent, it's not a bad idea, during that discussion to talk about the things we have in play now with some of the vendors, others may not know that A, we are doing this and B, that we are trying to move the agenda ahead.
- Response (Micky Tripathi): The HISP contracts will cover these kinds of issues. If we have a participant on eCW, that participant is bound by the HIway, but the vendor is in control of the technology. The vendor needs to explain what information is exposed.

Discussion Item 3: Mass HIway Update- Outreach & Sales Update (Last Mile Program)

See slides 6-18 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Mass HIway Update presented by Massachusetts eHealth Institute (MeHI) Health information Exchange Director Sean Kennedy.

(Slide 19) 2013 HIway Results-Outreach- 13 Interface Grants were awarded to vendors to build Direct connections, 6 vendors are actively testing and 2 have completed testing. There are at least 8 others being supported outside of the grant. A total of 32 Implementation Grants were awarded, representing 75+ trading partners. This will be a good opportunity to "blue print" for other practices. The Last Mile Program is working with 110 organizations.

The Fall Forum, regional meetings and webinars have been well attended. Use case workshops, educational materials and the eNewsletter continue to assist grantees.

(Slide 20) Program Evaluation Update- The Massachusetts Institute of Technology (MIT) is doing the Last Mile Program evaluation. As part of their analysis they are conducting key stakeholder interviews. The analysis requires a comparison with the current state versus the future state.

(Slide 21) Our Grantees and Collaborators Cross the State- There is a lot of coverage around the state; roughly 75 organizations signed on.

(Slide 22) Grantees and Collaborators by Organization Type - The Council was provided with a list of grantees and collaborators by organization type.

(Slide 23) How Do Grantees Intend to Use The HIway? - A good majority of uses cases are around care coordination, on both the sending and receiving side.

(Slide 24) What Are Grantees Measuring- The Council was provided with a sampling of metrics grantees are reporting.

(Slide 25) Grantee Challenges Remain- Grantees were asked to come up with one word to describe their challenges; the words are displayed in a word bubble, larger words being the more popular answers: vendor, staffing, consent, time funding and HISP-HISP.

(Slide 26) Top Reported Issues- A number vendors were not engaged early on, but are now beginning to engage. Organizations, especially on the smaller side, are figuring out how they will connect; a system could have practices join individually, or join under the hospital. There are a lot of configuration questions that are paralyzing for some of the grantees. Time and resources were another big issue; it is hard to get senior management to dedicate time.

(Slide 27) How Grantees Rated their Experience Connecting to The HIway- For the most part there was consistency; lack of resources available was also an issue.

(Slide 28) How Grantees Forecast Their Efforts- In the beginning grantees were asked to forecast effort, right now MeHI is gathering feedback on forecasted versus actual effort. For example, one of the IPA's came way under budget.

(Slide 29-30) Grantees Offer Feedback & Lessons Learned- It takes a number of different teams to make integration work; multiple departments need to be involved.

ONC State HIE Grant Update- It was confirmed in mid-November that the HIE state grant will not be extended beyond Feb 7, 2014. So, we will not get more time to spend all of the available funds. In a way it is good, as it allowed us to refocus. We have given guidance out to the grantees, we can definitively tell them now that this will not be extended. As an example grantees must meet milestones 1, 2 and 3, we are now allowing them more time to meet the third milestone. Some grantees will not get paid after February, but they can continue to receive assistance.

Last mile transition planning with EOHHS is underway.

- Comment (Manu Tandon): We are working on this now, talking with CMS about getting adoption going. We see a lot of activity around these use case but there is still a need to get more people to use the HIway.

February 6th: A Rally! A "HIway Transact-athon." MEHI is encouraging participants, in test or production, to send a transaction using the HIway and then tweet about it. This is a way to show ONC thanks for the 13 million dollars. It could also be an opportunity for hospitals and other organization to showcase efforts.

Implementation and Support Update presented by Manu Tandon.

(Slide 34) November Activity- There are 35 organizations in production and 22 live, a total of 57. organizations expanded into multiple use cases.

(Slide 35)New Agreements- A list of new organizations that have signed agreements was presented.

(Slide 36) Transactions- 129,045 transactions were exchanged in November totally 1,764,493 transactions to date. Continuing to focus on HISP to HISP, a team has been created to focus just on HISP connections. Work is being done with Meditech on their transport model.

(Slide 37) HISP to HISP Connectivity- Three key HISP vendors are engaged for implementation in January: eCW, Secure Exchange Solutions (SES) and Superscripts. Vendors ready to start testing in January include Aprima, MEDfx Corporation and McKesson Homecare and Hospice.

(Slide 38) HISP to HISP Connectivity (Cont.) - A list of vendors still in discovery phase, or awaiting testing agreements was provided.

(Slide 39) HIway Phase 2 Timeline- The cancer registry node is finishing testing this month. The go-live for Phase 2, release 1 is slated for January 2014. The Lead Poisoning Node will go-live in March and the Phase 2, release 2, will go live in the February-April 2014 timeframe.

Discussion Item 4: Wrap-Up

See slides 40-42 of the presentation. The following are explanations from the facilitator and comments, questions, and discussion among the Council members that are in addition to the content on the slides.

Wrap-up presented by Manu Tandon

EOHHS continues to work on an event; a demonstration of the Phase 2 services at BIDMC. Here is the scenario: A patient comes in, provider does not know much about the patient, he or she finds that the patient has a record somewhere and retrieves it to aid in the patient's diagnosis and treatment. This highlights the point that, absent the HIE, they would have had to do a number of repeat tests. Right now we are targeting the morning of January 8th. In March, lead poisoning registry will be available and live. In February – April we will keep making refinements.

There is still discussion around what we will call the event; suggestions are welcome!

The schedule for the 2014 HIT Council Meetings was provided; new invitations will be sent out.

- January 13
- February 3
- March 3
- April 7
- May 5
- June 9
- July 7
- August 4
- September 8
- October 6
- November 3
- December 8

** All meetings will be held from 3:30-5:00 PM at One Ashburton Place, 21th floor, in the Matta Conference Room.*

The Next HIT Council Meeting is scheduled for **January 13, 2014** from 3:30pm-5pm at One Ashburton Place, 21th floor, in the Matta Conference Room.

The HIT Council meeting was adjourned at 5:02 P.M.